AUTOMOTIVE INDUSTRIES WELFARE FUND

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Date: November 2014

To: All Plan Participants (except for Kaiser Participants) under the Automotive Industries Welfare Fund

From: Board of Trustees

This Participant Notice will advise you of certain material modifications that have been made to the Automotive Industries Welfare Fund Direct Pay Plans. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

OUT OF POCKET LIMITS ON COST SHARING FOR 2015

Currently, your Out-of-Pocket Limit on cost-sharing includes PPO copays, coinsurance and deductibles. We are pleased to tell you that starting January 1, 2015, the Fund is adding a limit to the amount that you pay for certain In-Network prescription drugs and a limit on the amount that you pay for mental health and substance abuse services in a calendar year.

These are new and separate limits from the Fund's existing Medical Out-of-Pocket maximum that limits the Medical coinsurance and deductibles that you may be required to pay in a year. This means that these new Out-of-Pocket Limits are the most money that you will have to pay for covered prescription drugs and mental health and substance abuse charges.

Once you have met your annual Medical deductible and coinsurance Out-of-Pocket maximum for the calendar year, medical covered charges will be paid at 100% coinsurance. Similarly, once you meet your Prescription drug copayment Out-of-Pocket maximum, your covered In-Network prescription drugs will be paid at 100%.
The Out-of-Pocket Limit on cost sharing is accumulated on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Fund.

The Out-of-Pocket Limit for in-network cost-sharing does not include or accumulate premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, penalty for failure to obtain precertification, outpatient retail/mail order prescription drug expenses, and out-of-network deductibles, dental & vision expenses (except for the Scheduled Dental Plan administered by ATPA), copayments and coinsurance except for emergency room visit in cases of an emergency.

Note that the medical plan does not have an out-of-pocket limit on the use of Non-PPO providers.

Please refer to the chart on page two for a detailed explanation on how your Out-of-Pocket maximums have changed.

OUT OF POCKET LIMITS FOR 2014	NEW OUT OF POCKET LIMITS BEGINNING January 1, 2015
Plans A and B **Medical:** • $1,500 Single • $3,000 Two Party • $4,500 Family In 2014 you do not have Out-of-Pocket maximums for prescription drug or mental health and substance abuse.	**Plans A and B** **Medical:** • $1,500 Single • $3,000 Two Party • $4.400 Family **Prescription:** • $1,500 Single • $3,000 Two Party • $4,400 Family **Mental Health and Substance Abuse:** • $1,500 Single • $3,000 Two Party • $4,400 Family
Plan C **Medical:** • $2,000 Single • $4,000 Family In 2014 you do not have Out-of-Pocket maximums for prescription drug or mental health and substance abuse.	**Plan C** **Medical:** • $2,000 Single • $4,000 Two Party • $4.000 Family **Prescription:** • $2,000 Single • $4,000 Two Party • $4,000 Family **Mental Health and Substance Abuse:** • $2,000 Single • $4,000 Two Party • $4,000 Family

NEW VALUE BASED PROGRAM EFFECTIVE JANUARY 1, 2015

There are wide treatment cost variations that exist in California for elective outpatient procedures and other types of surgeries, which cannot be explained by improved quality or clinical outcomes. In order to better manage the costs for certain surgical procedures, the Board of Trustees, along with Anthem Blue Cross, have developed a Value Based Program designed to keep your overall out-of-pocket costs down while limiting the overall increase in medical costs.

Outpatient surgeries can be more expensive when performed in an outpatient hospital rather than an Ambulatory Surgical Center (ASC). Effective January 1, 2015, payment for the following procedures when received in an outpatient hospital setting will be limited to the amounts listed below:

- Colonoscopy $1,500
- Arthroscopy $6,000
- Cataract Surgery $2,000

You will be responsible for any amount above these payment limits. If your surgeon believes that it is medically necessary to have one of these procedures done in an outpatient hospital setting, an exception may be granted and the payment limits stated above will not apply. You still have the same access to providers but **you will save money when you use a recommended facility.**

Total Hip and Knee Replacements

In order to manage the cost variance for hip and knee replacement surgeries, payment will be limited to a $30,000 maximum for a single hip joint replacement or a single knee joint replacement surgery effective January 1, 2015. This maximum includes all inpatient facility costs but does not include the professional fees such as anesthesia or surgeon fees. The Board of Trustees and Anthem Blue Cross have identified 52 facilities throughout California where these surgeries can be performed with little to no out-of-pocket costs beyond the plan's deductible, copays and coinsurance. See the attached list of approved Value Based facilities. You still have the same access to providers but will save money when you use a recommended facility.

If you are scheduled to have one of the surgeries listed above, please contact the Administrative Office so that you may be directed to a Value Based Facility.

Please see the attached "Care Comparison" from Anthem for important information on this exciting new program.

DOLLAR LIMIT ON NON-PPO SURGICAL CENTERS EFFECTIVE JANUARY 1, 2015

Beginning on January 1, 2015, a daily maximum of **$500** will be implemented for services received at an out-of-network Ambulatory Center.

SPECIALTY MEDICATIONS EFFECTIVE JANUARY 1, 2015

OptumRx Specialty Pharmacy and Clinical Management Program for Specialty Pharmacy Users:
OptumRx™ Specialty Pharmacy is the Fund's provider for specialty medications. Specialty Drugs are very high cost prescriptions that can include some injectables, inhalants and oral medications. Please note:

- Specialty drugs are limited to a 30 day supply.
- Specialty drugs must be filled using the OptumRx Specialty Mail Order Pharmacy.
- Shipping is at no charge to you for your 30-day supply.
- Participants taking HIV/AIDS medications can opt out of this program by calling 1-866-803-8570.

The Clinical Management Program (CMP) provides extra support at no cost to individuals with a condition requiring specialty medications. Members who enroll in a CMP will receive regularly scheduled phone calls with a personal clinician. These calls focus on helping members to better understand their condition and medications, teach ways to manage side effects, and provide other resources to help patients take a more active role in their treatment. **Participation is completely voluntary.**

To enroll, call the OptumRx Specialty Pharmacy at 1-877-839-7045. Ongoing support includes:

- One-on-one phone consultations with a pharmacist or nurse who is specially trained in your condition.
- During the first consultation, the nurse or pharmacist collects important background and medical information from you in order to learn about your unique needs and determine the best method of support for you.
- Follow-up consultations are scheduled as necessary
- Education materials and resources

Clinical Management Programs are available for a number of conditions including:

- Ankylosing spondylitis
- Hemophilia
- HIV/AIDS
- Multiple sclerosis
- Transplant
- Psoriatic arthritis
- Rheumatoid arthritis
- Crohn's Disease
- Hepatitis C
- Juvenile rheumatoid arthritis
- Oncology
- Psoriasis

Compound Medication Exclusion:
Compound medications are medications with one or more ingredients that are prepared "on-site" by a pharmacist using bulk chemicals. Many bulk chemicals are not approved by the Food and Drug Administration (FDA). No compound medication will be considered covered if any of the ingredients in the compound medication are either, not approved by the FDA *or* if any of the ingredients are separately excluded under the Plan.

Mail Service Pharmacy:
Save time and money by not driving to the pharmacy. OptumRx® Mail Service Pharmacy provides many benefits to members for those members on maintenance medications. Don't miss out on the savings that come with Mail Service and the convenience of having medications delivered right to your door. In addition you are entitled to a free **personalized medication review.** OptumRx has friendly customer service advocates available to take your call. You can contact a licensed pharmacist 24 hours a day, 7 days a week, by phone 1-866-218-5445. OptumRx is always here to help you, even after you have received your medications. There is never a charge for standard shipping.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may call the Fund Office at (800) 635-3105.

Sincerely,

Board of Trustees

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Fund Office.

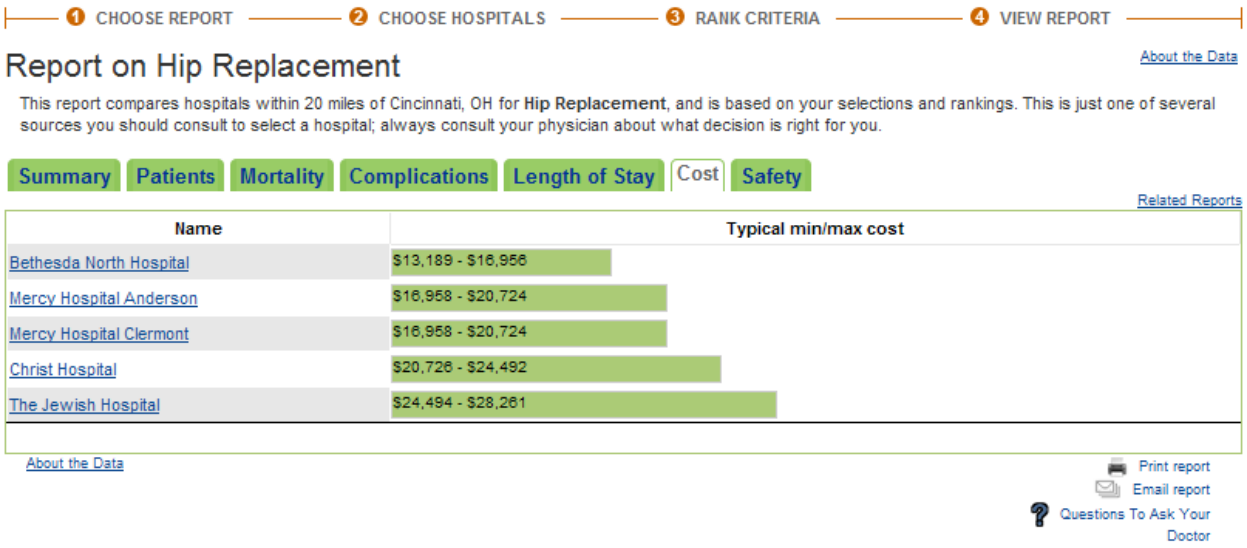
In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan. .

Anthem Care Comparison Tool

Care Comparison is an innovative shopping tool that discloses ***real*** price ranges for common services at specified area hospitals. As part of Anthem's commitment to transparency, **Care Comparison was designed to provide members with an easy-to-use comparison tool for informed decision making.**

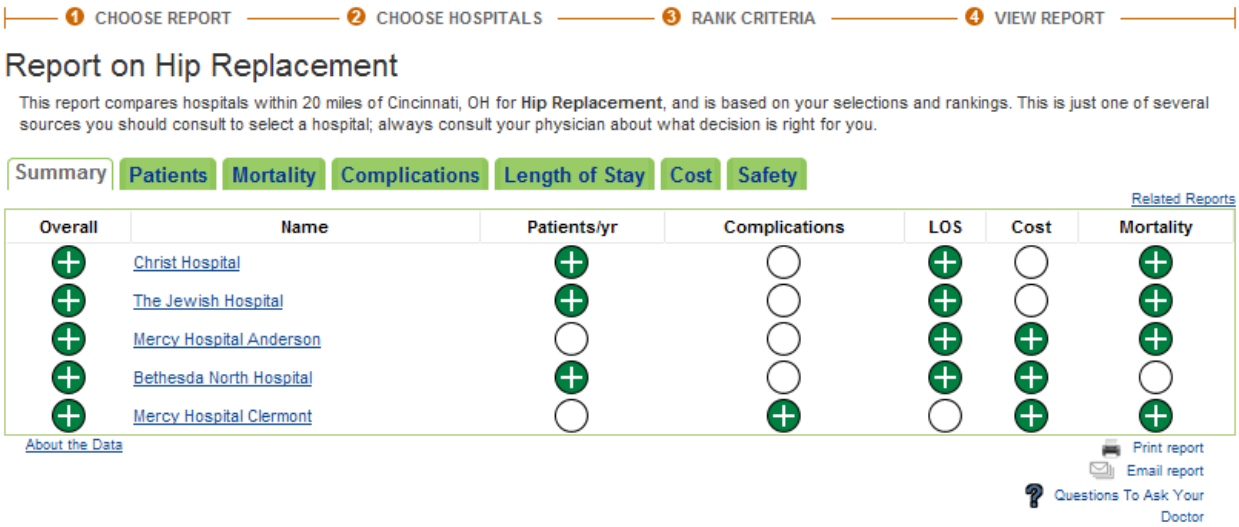
COST COMPARISON

Care Comparison offers side-by-side comparisons of all aspects of specific medical procedures. Not only will members find the estimated cost for procedures, but they may compare total costs at specified area hospitals. Care Comparison displays real cost ranges for an episode of care using facility-specific rates for ***59 medical procedures.*** Procedures were selected using commonly billed, high volume, non-emergent (or elective) procedures. Costs are bundled to include all services that are typically a standard part of a procedure or treatment including inpatient and facility, outpatient, diagnostic tests like radiology and even common office visits. Costs are displayed to members in cost ranges to show the likely overall cost of a given procedure. The ranges are calculated in 10% increments above and below the average cost, with the mid-range being plus or minus 5% of the average. Once the range for the procedure is calculated, each facility's total cost is assigned to the appropriate range.



QUALITY COMPARISON

Care Comparison provides ***measures of quality for 161 inpatient procedures and conditions*** obtained from state, federal and private sources. Quality measures include the number of patients treated (a key driver of quality), complication rates, average length of stay and facility-specific mortality rates.



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